Mental Health America

May 29, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-4207-NC. Request for Information regarding various aspects of Medicare Advantage (MA) data.

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the request for information (RFI) CMS-4207-NC that solicits feedback regarding Medicare Advantage (MA) data in several different categories of focus. Our comments are restricted to those areas that are most relevant to our organization and its mission.

Mental Health America (MHA) – founded in 1909 – is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the mental health of all. With nearly 200 affiliate organizations in 41 states, our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services, early identification, integrated care, behavioral health services, and supports.

As noted above, the RFI identified several different areas in which input was sought regarding data. We have chosen to comment on the following:

- Provider directories and networks
- Prior authorization and utilization management, including denials of care and beneficiary experience with appeals processes as well as use and reliance on algorithms

Provider Directories and Networks

We recently (May 20) submitted a letter regarding data collection in the quality bonus program (QBP) and the underlying star ratings that determine the bonus payments (letter transmitted through email to Meghan O'Toole and Doug Jacobs). While this RFI is not specific to the QBP, we do believe it is appropriate to restate here some of the areas of data collection we would like to see as our focus was on directories, networks, and access for mental health care.

There is clear evidence that many MA plans do not have adequate access to mental health care. A recent study found that almost two-thirds of MA plans had fewer than 25 percent of available psychiatrists in the network service area. This was significantly lower than what was found in Medicaid managed care and ACA plans. Further, this trend was not observed with any other physician specialty type in MA plans indicating that access to mental health treatment was substantially worse than access to other medical care.

And this only tells part of the story. A secret shopper survey conducted last year by the Senate Finance Committee found that over 80% of mental health providers listed in MA plans' networks were not actually available. Some could not be reached due to inaccurate phone numbers or unresponsiveness. Some were not accepting new patients. And some were not actually participating in the network despite being listed in the plan directory. Regardless, this indicates that these networks exist largely on paper only and in reality are ghost networks.

In our letter we identified several different points of focus for data collection and measurement, all focused on behavioral health.

The first area for measurement is the accuracy of MA plans' mental health and substance use disorder provider directories. At the very least, there should be a measure that evaluates whether the providers listed actually participate in the network and if the contact information provided is correct. This is a foundational component of being able to access care. If many or most mental health and substance use disorder providers listed in an MA plan's network aren't reachable or aren't really in the plan's network, it will be very difficult for enrollees to access care. This is especially the case for the roughly 60% of MA enrollees whose plans don't cover out-of-network services.

A related metric would be the percentage of providers listed in the network that had submitted zero claims in the previous six months. A high percentage would demonstrate that an MA plan had a misleading network and poorer access to care than what would appear by looking at the directory.

Average wait times for appointments with providers is another key metric that may be the very best measure of enrollees' ability to access mental health and substance use disorder care. Even if most providers in the network are reachable and they do in fact participate in the MH plan's network, long average wait times would indicate that the network's performance is poor, regardless of the on-paper appearances.

Another metric to consider is the percentage of providers who are accepting new patients or clients. While this may seem to overlap with some of the previous metrics, it is a distinct indicator of access to care within an MA plan network. A plan could have a very low percentage of inaccuracy in its directory. The plan could also have very few providers who have not submitted any claims in the previous six months. The average wait times for the plan could be relatively reasonable and not unduly lengthy. However, those circumstances could exist under scenarios where many of the providers are not taking new patients. Given that the demand for mental health and substance use disorder services is so great, and many providers do not take Medicare, there could be a considerable number of providers in an MA network who are accessible to their existing patient or clients but who simply do not have the capacity to take on any new patients or clients. This could be measured by examining the percentage of providers who had not submitted claims with new patients in the most recent six months compared to claims submitted in the six months prior to that.

Access to follow-up care after an initial appointment could be a final key indicator of whether an MA plan's network has the capacity necessary to meet the mental health and substance use disorder treatment needs of its enrollees. Access to initial care is of course vital, but if screening and diagnosis take place, or just screening alone, and there is no additional treatment that likely indicates that enrollees are not getting the services they need. Yes, there will be instances when this is enrollee-driven, but this should remain

constant across plans so if a plan has a high percentage of enrollees receiving no follow-up care compared to others, poor network performance and capacity are a likely culprit.

Prior Authorization and Utilization Management

Collecting and analyzing data on utilization review is important, both in terms of prior authorization and concurrent review. In terms of measuring denials, the data will be of little use if CMS does not establish structure and uniformity in how data is reported. For example, if an MA enrollee is pursuing an authorization for inpatient care at a psychiatric hospital, but that is not approved and instead partial hospitalization is approved, how is that reported? Is it a denial? Is it a partial approval? Is it considered an outright approval because the attending provider "agreed" to the lower level of care during a peer-to-peer review and no denial letter was generated? All three of those outcomes are real-world practices depending on the MA organization involved. There may be other possible outcomes to how an MA organization would classify the outcome of that authorization request. We do not intend to suggest that any of those ways is the right way, but instead we are stating unequivocally that there must be only one way and CMS must make clear what that way is and how to do it.

Post-service review is also important, but our experience with state regulators who regulate private insurers and Medicaid managed care organizations indicates that most health plans do not characterize many of their post-service review activities as "utilization review". They do so on the grounds that medical necessity is not reviewed, at least not directly or upon initial review. This is especially the case with what is often known as outlier review and with activities designed to detect fraud, waste, and abuse (FWA). Sometimes these two functions overlap and often they are performed by a health plan's special investigation unit (SIU). Whether one considers these activities forms of "utilization review" or not, they are common and often result in payment being denied, payment being withheld, payment being rescinded ("claw back"), pre-payment audit being imposed for some or all future claims, or an actual retrospective review that involves clinical information being initiated. Further, these activities have increasingly replaced prior authorization and concurrent review as a means of containing costs, particularly in the outpatient, office-based realm. And they are particularly prevalent in mental health and substance use disorder care.

Any collection and examination of data will be incomplete and lacking if these post-service forms of review are not analyzed, regardless of whether they are considered utilization review or not. These post-service and often post-payment reviews and then subsequent clawbacks cause providers to decline taking insurance, including MA. This leads to fewer in-network providers and poorer access to care, especially for behavioral health. CMS should require reporting on the prevalence of these reviews and their outcomes.

For all areas of focus CMS should provide clear definitions, structure, and uniformity to ensure meaningful data collection that can be used to compare plans, educate beneficiaries, and improve quality. Thank you for providing MHA with the opportunity to comment. For questions or further information, please contact us at mgiliberti@mhanational.org or at tclement@mhanational.org.

Sincerely,

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